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California Grant Application and Annual Report for the Maternal and Child Health Services Title V Block Grant Program

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Maternal Child and Adolescent Health / Office of Family Planning Branch
Children's Medical Services Branch
Primary Care and Family Health Division
Department of Health Services
State of California

Table of Contents

A. State Overview

Demographics

/2007/ California is the most populous of all US states, with 36.8 million residents in 2005, an increase of 539,000 over the previous year. One in every eight of the nation's residents lives in California. The state's population has increased annually since 1940, but the rate of increase has slowed each year since 2000, from 2.0 percent in 2000-2001 to 1.5 percent in 2004-2005. [1] California is the third largest state in terms of land area and is more than twice the size of 35 other states. [2] //2007//

The population increase is the result of the natural increase (the difference between the number of births and deaths), which accounts for a little over half of the total population increase, plus net migration to the state. Foreign immigration to the state far exceeded domestic migration for the period 2000-2005, with net foreign immigration totaling 1,165,624 and net domestic migration totaling 220,165. [3]

California residents are younger on average than the nation as a whole. The median age for the state in 2004 was 34, which is significantly lower than the median age in the US of 36. [4]

In 2003, there were almost 7.6 million women of childbearing age (15-44) in California. Women of childbearing age represent 22 percent of the state's total population. The 10.2 million children under age 19 account for 29 percent of the population, including 2.5 million under the age of 5 (7 percent), and over 500,000 under one year (1.5 percent). [5] Nationally, children ages 19 and under make up 28 percent of the population, and those under 5 make up 7 percent. [6] Between 2003 and 2009, the female teen population (ages 15-19) in California is projected to increase by 14 percent, and the Hispanic teen female population is projected to increase by 28 percent. [7]

Although the overall teen birth rate has declined steadily since 1991 (from 71 in 1991 to less than 38 in 2004), the decline among Hispanic teens has been slower, and Hispanics are disproportionately represented in the number of California's teen births. [8] Hispanics accounted for 71 percent of teen births in 2004 [9], while only accounting for 42 percent of the total teen population (age 15-19). [10]

Diversity

In addition to its overall population expansion, California continued to experience growth in its ethnic diversity. The fastest growing group is Hispanics. Hispanics, as a proportion of the state population, increased from 26 percent in 1990 to 32 percent in 2000. [11] By the year 2050 the percentage of Hispanics is projected to reach 54 percent, making it the majority ethnic group in the state, as well as the majority ethnic group for twenty counties. [12] In 2000, Whites comprised 47 percent of California's population, followed by Hispanics (32 percent), Asian/Pacific Islanders (12 percent), African Americans (7 percent), and American Indian/Alaska Natives (1 percent). [13]

In 2004, 27 percent (9.5 million) of California's population was foreign-born. [14] In 2002, 27 percent of the nation's immigrants (291,191) settled in California. Nearly half (49 percent) of these immigrants were born in Latin America and the Caribbean, primarily Mexico, and 39 percent were born in Asia. [15]

In California, Hispanics are younger on average than members of other racial/ethnic groups, and this age differential is increasing. The median age of Hispanics in California in 2004 was 26, eight years younger than that of the total population (34). Among Whites, the median age was 40, and for Asians, the median age was 36. [16] Hispanic children comprised the largest proportion of school children during the 2004-2005 school year, making up 47 percent of students in California. [17]

Racial/ethnic diversity and a large immigrant population contribute to linguistic diversity in California. In 2004, 41 percent of California residents over the age of five spoke a language other than English at home, compared to 19 percent nationwide. Most often this language is Spanish, however, a variety of Asian and Pacific Island languages are also spoken. [18]

Geography

California is comprised of 61 local health jurisdictions, including 58 counties and three incorporated cities. These local health jurisdictions vary widely in geographic size, number of residents, and population density. In terms of geographic area, San Bernardino is the largest county, and San Francisco, San Mateo, and Marin Counties are the smallest. Los Angeles County is the largest in terms of population, with over 10 million residents, 28 percent of the state's total population. Alpine County has the smallest population, with fewer than 1,300 residents. [19]

Most of the state's population (98 percent) resides in urban areas [20]. Los Angeles, San Diego, Orange, Santa Clara, and San Francisco Counties all have large urban populations. Some counties, such as Fresno, Monterey, and Santa Barbara, are primarily rural but contain urban centers where most of the population resides.

Most counties in the state experienced population growth between 2000-2004, although the rate of growth appears to be slowing. Riverside and Placer Counties grew at the highest rate, increasing in population by approximately 4 percent each year. [21] Other counties projected to experience large increases in population include San Joaquin, Merced, and Madera.[22] From 1999-2004, Sierra was the only county with a net loss in population, but Alpine and Marin Counties were at or close to a zero growth rate. [23]

Economy

In 2004, the State of California's gross product ranked eighth in the world. [24] This is in spite of the fact that California has not shared completely in the economic growth the nation has experienced recovering from the recent economic recession. California's unemployment rate in 2005 was 5.4 percent, compared to the national rate of 5.1 percent. The drop in the unemployment rate in Fiscal Year (FY) 2003-04 was the first drop in unemployment since FY1999-2000. [25] The forecast through 2008 projects that California's unemployment rate will not fall or change significantly, suggesting that the slow pace of economic growth in the state will continue. [26]

The stagnant economy in the state has resulted in budget cuts that have affected maternal and child health programs and services. The state has experienced restrictions on the creation of new contracts, purchasing of equipment, hiring of staff, and travel. This has

curtailed the ability of State programs to provide technical assistance and training to local health jurisdictions, compromising the ability to improve and sustain program quality.

Restrictions on State programs and services compound existing challenges faced by California's residents who live near or below the federal poverty level (FPL). The US Census Bureau estimates that in 2004, 13.3 percent of California residents lived below the FPL. This is worse than the national rate of 13.1 percent and ranks California as the 20th worst state in terms of residents in poverty. [27] Three counties in California's Central Valley ranked among the most impoverished counties in the nation: Tulare, with 20.3 percent of residents living below the federal poverty level, Kern, with 19.3 percent, and Fresno, with 17.9 percent. [28]

The federal definition for low-income is household income of less than 200 percent of the poverty level; however, in parts of California, the high cost of living creates stress for families whose incomes are not necessarily low by this definition. In 2004, California had the highest median monthly rental housing costs ($914 per month) in the nation, and ranked 49th for home ownership among residents. [29] The population growth occurring in California only compounds this problem, as the construction of new housing units cannot keep up with increasing demand.

While the actual cost of housing varies between different regions in California, the problem exists throughout the state. Even in lower-cost areas, affordable housing is becoming increasingly scarce. In California's rural counties, a family would need to earn at least $10.33/hour (153 percent of minimum wage) working full-time in order to afford a Fair Market Rent apartment ($537/month for a two bedroom apartment). [30]

Homelessness is also an ongoing problem for the state. For example, in Alameda County, an estimated 12,000 people are homeless on a given night, and approximately 40 percent of those are families with children. [31]

Of the 4.6 million households with one or more children under 18 in California, 19 percent are headed by a single female parent. [32] These households are more likely to struggle to support themselves with less than adequate income.

Single parenthood, low income, and high housing costs, along with welfare reform, force most women with children into the labor force. Of the almost 6.5 million women in California between the ages of 20 and 44 (as of March 2004), 70 percent participated in the labor force. [33]

The proportion of women in the labor force, coupled with the number of single-parent households in California, creates an enormous need for childcare for working parents. Unfortunately, licensed childcare is available for only 26 percent of children with parents in the labor force. The cost of childcare for a preschooler typically consumes 53 percent of a parent's income if the parent is working full time at minimum wage. [34]

Hispanics and African Americans are disproportionately low income. The 2003 median household income was $36,000 for Hispanics and $40,000 for African-Americans, both well below the state's median household income of $49,320. The median household income for Whites and Asians was $71,474 and $67,064 respectively. The proportion of California residents living in poverty (<100 percent FPL) shows similar racial/ethnic disparities: 22 percent for African Americans, 21 percent for Hispanics, 11 percent for Asians, and 8

percent for Whites. Fifty percent of Hispanics and 43 percent of African Americans were classified as low income (<200 percent FPL). [35]

There are currently more than 6 million school-aged children in California and more than 9,000 schools. [36] Hispanic students comprise the largest and fastest growing racial/ethnic group in California schools. Of the student population, 49 percent receive subsidized school lunches. Over one quarter are classified as English learners; most of these English learners' first language is Spanish. [37]

Health Care Status

In California, 18 percent of the population did not have health insurance in 2002, compared to 15 percent of the US population. Among California's Hispanic population, 31 percent were uninsured. Among California children under the age of 18, 14 percent were uninsured. Among California children, 28 percent were covered by Medicaid or Healthy Families, compared to 25 percent for the US. [38] Among the poor and low-income population in California, children were more likely to be covered by public programs than adults. Continuing to raise the rates of enrollment in public insurance programs, especially among immigrants and non-English speaking populations, remains a challenge for the state.

Another challenge for the state is meeting the health care needs of the large number of undocumented immigrants, many of whom are migrant workers. While the number of undocumented immigrants in California is difficult to measure, a recent study suggested that 2.4 million undocumented immigrants were in the State of California in 2002, over a quarter of the nation's estimated 9.3 million. It is estimated that 40 percent of the undocumented immigrants are women. [39] In one sample of undocumented immigrants in Fresno and Los Angeles Counties, half were between the ages of 18 and 34, and one quarter were children under 18. [40]

It is not surprising that, given the complicated nature of eligibility for public assistance, coupled with fear of the consequences of having to reveal one's status as undocumented, that access and participation in available services among the undocumented population is very low. Still, the most common reason given by undocumented immigrants for not seeking health care was that it was too expensive. [41] Other complications arise for undocumented immigrants who seek services in one county, then move on to another region for work. This makes it difficult to provide consistent and comprehensive services and to track services rendered to this population.

Challenges in meeting the diverse needs of mothers and children also arise as a result of increasingly varied family and household structures that exist in California. For example, in addition to the large proportion of female-headed households with children, a growing proportion of children are living with grandparents. In 2004, over 860,000 grandparents stated that grandchildren were living in their home. In 29 percent of these households, the grandparents reported that they were the primary caretakers for the grandchildren living in the household. Of those responsible for grandchildren, 58 percent were working, and 16 percent were living in poverty. [42]

The aging of the state's population also has an impact on the health and well-being of mothers and children. In California, 16 percent of all households contain at least one caregiver for someone aged 50 or older. Three quarters of those caregivers are women, and 31 percent have their own children living at home. This can pose a financial and emotional

burden on families, particularly those who are low-income and/or have working mothers. About half of California caregivers reported they were employed. One third of caregivers reported high emotional stress due to providing care. [43] Addressing this growing stress on families is likely to become an increasing challenge in the future, as the proportion of the population over age 50 grows and the cost of living forces many households to consolidate and increase in size.

The diverse nature of California's population and geography, coupled with the changing face of the population demographically, socially, and economically, proves to be a continuing challenge for the programs of California's Maternal Child and Adolescent Health / Office of Family Planning (MCAH/OFP) Branch and Children's Medical Services (CMS) Branch.

Major State Initiatives

/2007/

> Impact of Federal Title V reductions on California’s Maternal, Child and Adolescent Health Programs

Due to cuts in Title V funding this year, several MCAH/OFP programs have been eliminated or had their funding substantially reduced. The following programs and projects have been eliminated: Adolescent Sibling Pregnancy Prevention Program; technical assistance to local health jurisdictions for adolescent health improvement; and the training program for Adolescent Family Life Program (AFLP) case managers. The following have received funding reductions of more than $85,000/year each: the Adolescent Family Life Program; support services for the Childhood Injury Prevention Program; the Oral Health Program; staff support for MCAH program development; and technical assistance to local health jurisdictions from the Family Health Outcomes Project. Following is a description of the impact of these cuts.

The Adolescent Sibling Pregnancy Prevention Program (ASPPP) was eliminated in March 2006, a budget reduction of $2.3 million a year. Siblings of pregnant and/or parenting teens and their families will not receive services that assist the siblings to stay in school, encourage their use of health and safety practices, and work to prevent early onset of sexual activity and prevention of teen pregnancy. Early evaluation of ASPPP indicated decreased incidence of pregnancy in the target population for those siblings participating in the program. Elimination of the program may negatively impact California’s efforts to reduce teen pregnancy.

The contract for technical assistance to local health jurisdictions on adolescent health improvement has been eliminated, a budget reduction of $100,000 a year. As a result, technical assistance will no longer be provided to local health jurisdictions planning and implementing the recommendations provided by the Adolescent Health Improvement plan. This may result in decreased local ability to implement effective local efforts to impact the health of adolescents in their jurisdictions.

Funding for training of case managers for the Adolescent Family Life Program (AFLP) has been eliminated, a reduction of $88,000. The training provided information and skills necessary to work successfully with AFLP clients to help achieve program goals of healthy birth outcomes, improved parenting skills and completion of high school.

Funding for the AFLP Program has been reduced by $154,000. Fewer teens and their families will receive services needed to improve birth outcomes, ensure teen program participants complete high school, and learn important parenting skills. Reduction in the number of clients served adversely impacts the outcomes for pregnant and parenting teens who will not have access to AFLP services.

Funding for the support contract for the Childhood Injury Prevention Program (CIPP) has been reduced by $127,000. The reduction eliminates funding for the annual statewide Childhood Injury Prevention Conference and reduces technical assistance provided to local health jurisdictions.

Funding for the Oral Health Program has been reduced by $100,000. The goals of the Oral Health Program are to review, monitor, and improve oral health capacity for women, adolescents and children in California. The reduction in funding decreases the ability to provide necessary interventions, to collect data, and to collaborate with other health and oral health programs.

Funding for one senior staff position in MCAH Program Development has been eliminated, a reduction of $150,000. Loss of this position means reduced staff capacity in the areas of policy analysis, data analysis, program development, program evaluation, and Title V reporting.

The contract for technical assistance to local health jurisdictions from the UCSF Family Health Outcomes Project (FHOP) has been reduced by $150,000. FHOP provides technical assistance to local health jurisdictions in reviewing and evaluating data for local needs assessments, a key component of the Title V Plan. FHOP has developed and/or adapted standardized approaches to health outcomes monitoring; longitudinal tracking and unique client identification. The reduced funding will decrease the number of local jurisdictions receiving agency-specific technical assistance, reduce the number of training sessions and support publications, and decrease the amount of technical assistance provided to the state-level MCAH program.

> Preconception care

The MCAH/OFP Branch is collaborating with and supporting the efforts of the American College of Obstetricians and Gynecologists (ACOG), the California Academy of Family Physicians, the March of Dimes (MOD), the UCSF Center for Health Policy Studies, and Sutter Medical Center Sacramento to improve the practice of preconception care in California.

Through the California Preconception Care Initiative, a provider/patient resource packet has been developed to assist health care providers in the provision of preconception care. A summary of the literature provides an overview of the evidence for preconception care. Patient education handout topics include: smoking cessation; medical conditions and genetic counseling; domestic violence; folic acid use; diabetes control; infections and immunizations; and healthy lifestyle choices. In addition to the packet, clinical information has been disseminated through the Internet, regional conferences, DVD, and audio presentations.

Other states are adapting materials from California's provider/patient resource packet for their own use. The materials were distributed across the country by the National Birth

Defects Prevention Network in January of 2006 and are currently available for download on the March of Dimes California Chapter website. Plans are in place now to update the packet.

Over the past year, the MCAH/OFP Branch has taken a leading role in promoting preconception health and healthcare. In November 2005, the Branch convened a meeting of representatives from city, county, and state health agencies, as well as representatives from MOD and Sutter Medical Center, to discuss areas of potential collaboration.

The California Preconception Care Advisory Committee was represented, by one of its members, on the Surgeon General's Select Panel on Preconception Care. This group is providing recommendations for the nation on preconception health and healthcare. The recommendations were released in April 2006.

The California Chapter of MOD, together with the MCAH/OFP Branch, convened the State of California Preconception Care Advisory Committee Meeting, held in May 2006, to discuss a comprehensive, state-wide plan of action to both promote and ensure access to preconception care for women of childbearing age in California. The lead program officer from CDC and lead author of the recommendations for the nation were featured speakers. Several senior managers from MCAH/OFP participated. The committee will be meeting quarterly to prioritize the recommendations, develop a plan of action for California, and oversee implementation. Several members of the committee will be serving on CDC workgroups to further develop national strategies for preconception care.

The MCAH/OFP Branch is cognizant of the importance of developing and implementing Preconception Care policies that are internally consistent within CDHS programs, as well as being congruent with regional and national initiatives external to the Department. Within the CDHS, an important strategy will be to integrate Preconception Care initiatives and patient educational programs among primary care services, family planning services, and pregnancy care services, since each of these sites of clinical care may be utilized by the same individual woman, but at different times in her life. A lesson learned from the unsuccessful Preconception Care initiatives carried out in the 1990s is that isolated initiatives targeted at single provider types are not enough. Instead, the integrated, consistent, and clear guidance that a woman receives from each type of health care provider that she sees, as well as the public health educational messages that she encounters, are critical motivators in leading to the behavioral changes that are necessary to achieve the goals of preconception care.

Local MCAH health jurisdictions have also undertaken activities related to preconception care. A prime example is the Los Angeles Collaborative to Promote Preconception/Interconception Care, which is comprised of Los Angeles County MCAH Programs (LA MCAH), LA Best Babies Network (LABBN), and the local chapter of the March of Dimes (MOD).

The LA County Collaborative is serving in a leadership role to implement and monitor the success of various preconception/interconception care models including 1) convening a policy roundtable to discuss financing of interconception care for women at highest risk; 2) developing a Care Quality Framework which includes incorporation of preconception/interconception care; 3) providing interconception care case management for the highest risk women who have had an adverse birth outcome; 4) providing funding for prevention interventions for preconception/interconception clients; 5) surveying family needs and challenges to accessing interconception care; 6) promoting pregnancy and

family friendly policies for employers; 7) implementing an evaluation framework that demonstrates the health and cost benefits of providing preconception/interconception care, as well as the elements critical for replication in other areas**.** This effort is largely supported by First 5 LA Healthy Births Initiative ($28 million) and LA MCAH.

//2007//

The MCAH/OFP Branch has applied to the Centers for Disease Control and Prevention (CDC) for a Prevention Specialist (PS) for a period of two years to serve as the lead for a Statewide Preconception Health Task Workgroup. /2007/ The request for the PS was not funded. //2007//

>Safe motherhood

Each maternal death is tragic and represents a premature loss of life. Much of maternal morbidity and "near miss" mortality goes unnoticed by traditional public health surveillance systems and can impact maternal, fetal, and infant health.

Modeled on the California Perinatal Quality Care Collaborative (CPQCC), the MCAH/OFP Branch has developed a Maternal Quality Collaborative (MQC) to address maternal morbidity. CPQCC uses data-oriented quality improvement activities to improve perinatal and neonatal outcomes. The MQC is a collaborative effort between the CPQCC and the UCLA Maternal Quality Improvement Group. The MQC Leadership Council includes members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. MQC measures maternal quality of care in California and has begun to identify hospital-level outcomes for maternal/neonatal infections and postpartum hemorrhage.

Over the past year, the MCAH/OFP Branch has also developed a Pregnancy-Related and Pregnancy-Associated Mortality Review Project. Maternal mortality ratios remain much higher than the Healthy People 2010 objective and racial and ethnic disparities in mortality are large. The goal of this project is to is to examine the medical and psychosocial events leading up to death for women who died from pregnancy-related causes or within one year of pregnancy (pregnancy-associated deaths) so that MCAH/OFP Branch and its stakeholders can develop a public health component to reduce such deaths.

The MCAH/OFP Branch is partnering with UCSF and the Public Health Institute (PHI) to conduct this study. The study team will identify sample cases and will abstract medical records for the antenatal, peripartum, and postnatal periods, using forms based on models provided by the CDC. A Case Review Team will review de-identified case summaries and determine whether deaths were due to pregnancy-related factors or linked to the period after pregnancy by time only. MCAH/OFP Branch, UCSF, and PHI will report findings and work with stakeholders to disseminate findings and develop next steps for action.

/2007/ The Maternal Quality Collaborative is now named the California Maternal Quality Care Collaborative (CMQCC). Dr. Elliott Main of the California Pacific Medical Center chairs the CMQCC Advisory Committee and is leading the collaboration and coordination of the CPQCC and the UCLA Maternal Quality Improvement (MQI) group. The third- and fourth-degree laceration rate of hospitals has been chosen as the first indicator for which the CMQCC will implement best practices while development and validation of other indicators proceeds. //2007//

/2007/ The MCAH/OFP Branch also collaborated with the CDC Unexplained Deaths and Critical Illnesses Project (UNEX), the CDC Division of Reproductive Health and the CCDHS Unexplained Deaths Project to investigate the death of four women in California who died after medical abortions in 2003-2005. These deaths were attributed to infection by Clostridium sordellii, and warnings about medication and route of administration were issued by the CDC and the U.S. Food and Drug Administration during this investigation. //2007//

/2007/ The MCAH/OFP Branch is implementing the Pregnancy-Related and Pregnancy-Associated Mortality Review Project (PAMR). Chart review abstraction forms have been developed and approved by the relevant institutional review boards. Administrative data necessary for case identification has been linked. Sixty of the 194 cases identified through this linkage file have been selected for in-depth review. PHI is communicating with hospital medical records personnel to obtain permission to abstract data for these cases in the summer and fall of 2006. The MCAH/OFP Branch, UCSF and PHI have made a 5 year commitment to the continuation of this project. //2007//

> Early childhood development

Proposition 10, the Children and Families First Act (implemented in 1998), imposes a surtax on cigarette sales, which generates revenues of about $600 million a year. The state-level commission, First Five California, receives 20 percent of the funds, while local First Five Commissions in each of the 58 California counties receive 80 percent. First Five California has devoted $207 million over four years (2002-2006) to its signature School Readiness Initiative (SRI). Health and social services are essential elements of SRI.

First Five has four other efforts addressing early health. They are 1) Childcare Health Linkages; 2) The Infant, Preschool and Family Mental Health Initiative; 3) the Childhood Asthma Initiative; and 4) the Oral Health Initiative. The MCAH/OFP Branch follows the activities of First Five and helps local staff prepare SRI proposals and identify the connections between their programs and First Five activities.

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

> Child health insurance coverage

Another major state initiative is improving the health of the Title V population through expanded health insurance coverage. Efforts to increase enrollment in the state-sponsored children's health care programs, including Medi-Cal and Healthy Families, appear to be reducing the percentage of uninsured children.

/2007/ Since the inception of the CHDP Gateway in July 2003 and through February 2006, over 1.9 million children receiving CHDP assessments have been pre-enrolled for up to two months of no cost full-scope Medi-Cal benefits. Families of 70 percent of these pre-enrolled

children have requested joint applications from Medi-Cal/Healthy Families (HF). Of these, 20 percent had their eligibility extended for Medi-Cal/HF. //2007//

/2007/ Effective June 2004, the CHDP Gateway was enhanced to allow deeming of Medi-Cal eligibility for infants if their mother's eligibility for Medi-Cal at the time of birth was confirmed. Eligibility is extended until the first birthday without requiring their parent(s) to complete a joint Medi-Cal/HF application. From June 2004 through February 2006, 102,449 infants were automatically enrolled in Medi-Cal as the result of a Gateway transaction. //2007//

> Oral health promotion

The California Department of Health Services (CDHS) is responding to the high prevalence of dental disease among California's children with a variety of strategies to increase awareness of oral health. MCAH/OFP Branch staff work to ensure the inclusion of oral health promotion activities within existing programs of the Branch. Comprehensive Perinatal Services Program (CPSP) guidelines have been revised to include oral health guidelines for pregnant and postpartum women. Toothbrushes and children's fluoride toothpaste have been distributed to domestic violence shelters as well as local MCAH programs including the Adolescent Family Life Program (AFLP) and the Black Infant Health (BIH) Program.

The MCAH/OFP Branch is contracting with University of California San Francisco (UCSF) for an oral health epidemiologist and a dental hygienist to serve as MCAH/OFP Oral Health Policy Consultants to meet the growing demand for technical assistance at both the state and local levels. The contract is awaiting state approval. The Oral Health Policy Consultants will work with Branch programs as well as being involved with the State First Five Commission.

/2007/ The contract was approved, but has subsequently been reduced due to budget cuts. The epidemiologist position has been eliminated. //2007//

The California First Five Commission has developed an Oral Health Initiative which consists of 1) a $7 million Early Childhood Oral Health Education and Training Project, and 2) a $3 million Insurance-Based Oral Health Demonstration Project. Provider training began in 2004 and will last for the four years of the grant.

/2007/ In FY 2003-04, 1,788,460 children received dental screenings through the CHDP program, a decrease of one percent from FY 2002-03, following a 4 percent increase from FY 2001-02 to 2002-03. CMS Branch staff continue to meet with Denti-Cal to work on solutions for improving access to dental/orthodontic care for children enrolled in the California Children’s Services (CCS) program. //2007//

> Preventing childhood obesity

California, like the nation, is experiencing an increase in the prevalence of obesity and related health problems. The CDHS Director has established a CDHS Nutrition and Physical Activity Action Team with representatives from both MCAH/OFP and CMS. The Action Team has proposed a $6 million Obesity Prevention Initiative consisting of community action projects, a health quality collaborative, tracking and evaluation of data, worksite

interventions, and public awareness and education activities. Both MCAH/OFP and CMS are also involved in the Physical Activity and Nutrition Coordinating Committee (PANCC).

/2007/ Childhood obesity in low-income children is assessed through the Pediatric Nutrition Surveillance System (PedNSS) data that are now on-line on the CMS Branch website. Data for 2004 show that the percentage of low-income children under 5 years receiving healthcare through CHDP who are overweight is essentially unchanged from the prior two years (16.2 percent) at 16.3 percent. However, for children 5 to 20 years, the percent overweight has continued to increase annually and is 22.4 percent for 2004 (21.7 in 2003, 20.8 in 2002). The prevalence for at risk for overweight for children 2 to 20 years remains unchanged from 2003 to 2004. Ethnic variation in the prevalence of overweight still exists, with the highest prevalence in American Indian/Alaskan Native, followed by Hispanic children. //2007//

MCAH/OFP programs, including AFLP, the Adolescent Sibling Pregnancy Prevention Program (ASPPP), BIH, California Diabetes and Pregnancy Program (CDAPP) and CPSP, promote healthy eating, physical activity, and breastfeeding. The MCAH in Schools program promotes a comprehensive school health system, including physical education and healthy food choices.

/2007/ Due to budget constraints, the ASPPP was eliminated in March 2006. //2007//

The California Nutrition Network for Healthy, Active Families is a public/private partnership led by CDHS. The purpose of the Network is to promote healthy eating and a physically active lifestyle among low income Californians by using social marketing techniques to reach large numbers of people. In addition to CDHS, Network partners include the Department of Social Services (DSS), the Department of Education (CDE), the Department of Food and Agriculture, and the University of California (UC) Cooperative Extension.

/2007/ Nutrition Network funding for CHDP local programs ended in 2005. However, collaboration between MCAH agencies and local school districts has resulted in improved nutritional standards for school meals and campus snack machines, increased physical education activities and incorporation of healthy lifestyles education into school curricula. Outreach and education regarding healthy lifestyles are commonly presented to community groups, parents, caregivers and staff at child care centers and incorporated into protocols for home health visits. Walk-to-school days have been organized in several counties. //2007//

> Eliminating racial and ethnic disparities in health

Racial and ethnic disparities continue to exist in the areas of infant mortality, neonatal mortality, preterm delivery, low birth weight and maternal mortality in California. The MCAH/OFP Branch makes cultural sensitivity a cornerstone of every program activity, including AFLP, the Battered Women's Shelter Program (BWSP), BIH, CDAPP, and CPSP.

CDAPP incorporates cultural competence awareness in all CDAPP trainings and materials. At-risk women, including Hispanic, African American, and Asian/Pacific Islander women, are targeted. Direct services are provided by a well-trained, ethnically diverse work force of diabetes and pregnancy specialists. Food plans are developed to include foods that are compatible with the dietary customs of each client.

California's BIH programs have served as a national model by successfully identifying and enrolling the highest risk population, pregnant and parenting African-American women, for focused interventions. Comprehensive services offered to this population include the development of client-centered, culturally sensitive education, case management, and prenatal and pediatric care.

State outreach efforts have been designed to reduce the disproportionately high rates of uninsured among California's ethnically diverse populations. To improve access to Medi-Cal services, all Medi-Cal Managed Care (MCMC) materials are to be made available in ten threshold languages: Spanish, Chinese, Vietnamese, Cambodian, Hmong, Laotian, Korean, Russian, Farsi, and Tagalog.

> Adolescent health promotion

The State has formed the California Initiative to Improve Adolescent Health, based on the National Initiative to Improve Adolescent Health by the Year 2010. In response to the interest among county MCAH directors and local agencies, the MCAH/OFP Branch contracted with the National Adolescent Health Information Center (NAHIC) at UCSF to work with local programs to promote the plan and provide technical assistance in the development of activities.

/2007/ Due to Title V budget cuts, the adolescent health improvement contract with NAHIC has been eliminated. //2007//

NAHIC produced the Guide to Adolescent Health Data Sources to assist local MCAH Directors and others interested in adolescent health to better assess the needs of youth in their community. In addition, a California Adolescent Data Update on Intentional and Unintentional Injury was developed for dissemination at the California Conference on Childhood Injury Control.

> Black Infant Health / Fetal Infant Mortality Review

In response to the persistent disparity between African-American and White infant mortality rates, the MCAH/OFP Branch has begun the Black Infant Health/Fetal Infant Mortality Review (BIH/FIMR). The goal of BIH/FIMR is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight BIH jurisdictions were selected for participation; all had an African-American combined fetal and infant death rate above the average for the 17 BIH jurisdictions statewide, and all had a FIMR program.

BIH/FIMR uses the National FIMR model to collect detailed information about African-American fetal and infant deaths beyond vital statistics. Data will be centrally collected and reportable at the state and county level. The program will train local FIMR coordinators and increase collaborative community involvement through BIH. A state-level BIH/FIMR team will be created to address state-level systemic issues.

/2007/ The Branch is finalizing a contract with Bassinet for a centralized BIH/FIMR data collection system. BIH FIMR coordinators will be trained in its use. //2007//

/2007/ Utilizing data obtained from BIH/FIMR, the Los Angeles MCAH Program implemented the LA Mommys and Babies Survey (LAMBS) in the Antelope Valley. While

the African American infant mortality rate decreased from 2002 to 2003, it still remains high when contrasted with the infant mortality rate for other ethnicities. Also of concern is the increase in infant mortality for Hispanic babies evidenced by the survey. LA MCAH has undertaken efforts to reduce infant mortality in both African American and Hispanic communities through enhanced access to quality, culturally sensitive obstetrical care for at-risk women, including home visitation and assistance with psychosocial issues. //2007//

> Foster care

Children and youth in foster care settings are high-risk individuals who often do not receive necessary health care evaluations and services. California has over 84,000 foster children. To improve access to and oversight of health care for these children, the Health Care Program for Children in Foster Care (HCPCFC), a collaboration between DSS and CMS, was initiated in January 2000. This program, administered locally by the CHDP program, places public health nurses (PHNs) in administrative case management positions in welfare service agencies and probation departments to assure delivery of comprehensive preventive, diagnostic and treatment health services to children and youth in foster care and to serve as a resource on the unique health care needs of children and youth.

/2007/ California now has approximately 93,000 foster children. For FY 2005-06 HCPCFC has 255 public health nurses in administrative case management and supervisory positions in welfare service agencies and probation departments. //2007//

The foster care PHNs have formed a Statewide Foster Care Executive Subcommittee (of the CHDP Executive Committee) which serves the function of providing leadership to promote standardization of nursing practice in Child Welfare and Juvenile Probation in California. The Subcommittee advises the Executive Committee on program issues relating to the goal of increasing access to preventive health, dental, developmental and mental health services for children and youth in foster care. The Subcommittee provides a link to the five Regional Foster Care PHN groups through its membership, dissemination of minutes, and sharing of information relevant to health services for children and youth in foster care.

/2007/ The Subcommittee has developed four best practice guidelines for HCPCFC PHNs statewide: (1) assurance of continuity of care and case coordination among PHNs; (2) universal review and updates of the content for the Health and Education Passport (HEP) or its equivalent; (3) consultation and care coordination for out-of-county placement; and (4) guidelines for the PHN working in the juvenile probation departments. //2007//

The HCPCFC PHN directory (including state staff) and other information is online at www.dhs.ca.gov/pcfh/cms/hcpcfc/.

> Mental health

California's MCAH/OFP Branch is working to address the mental health needs of infants, children, adolescents, and mothers. The Proposition 63 Mental Health Services Act (MHSA) provides funding for the expansion of mental health services for adults and children using revenue from an additional 1 percent tax on income over $1 million. MCAH/OFP staff participate in the MHSA stakeholder group.

Many MCAH/OFP Branch programs include a mental health component, including AFLP, BIH, CDAPP, CPSP, and DV. All include assessment and referral, and some include treatment as well. Interventions may include counseling for an individual, family or group, and may address psychiatric illness, marital and family problems, alcohol and substance abuse, smoking cessation, depression, eating disorders, etc.

The MCAH/OFP Branch participates in statewide efforts to implement coordinated mental health services. Three such efforts currently underway are the Behavioral, Emotional, and Social Screening and Treatment for Primary Care Providers (BEST-PCP) Project; the State Early Childhood Comprehensive Systems (SECCS); and the School Readiness Initiative (SRI).

BEST-PCP brings together state agencies, including the MCAH/OFP and CMS Branches, and stakeholders to improve access to services promoting healthy mental development for children age 0-3 who are enrolled in MCMC. A model quality improvement project (including training tool) is being implemented in two counties.

The SECCS project, funded through a HRSA grant, provides state-level leadership for programs that will help California's children to be emotionally, socially, and physically ready for kindergarten. The project coordinates various health-related programs of state and local government with organizations such as the American Academy of Pediatrics (AAP), March of Dimes, Easter Seals, and representatives of faith-based organizations.

The SRI is the signature initiative of First Five California. Mental health counseling is one of the five "essential and coordinated elements" of SRI. It is anticipated that the SECCS initiative will strengthen the health component of the SRI, including mental health.

>Fetal Alcohol Spectrum Disorder (FASD)

The MCAH/OFP Branch aims to improve birth outcomes for women at risk of alcohol use/abuse, including screening and referral for treatment services. Community-based prevention programs, including CPSP, BIH, AFLP, ASPPP, DV, and CDAPP, provide clients with information about FASD, identify those at high risk, and refer them for alcohol treatment services.

The MCAH/OFP Branch participates in a Statewide FASD Task Force. The Task Force meets quarterly and consists of representatives from state agencies and local communities. Their mission is to encourage best practices for prevention and provide intervention to those affected by FASD.

Many local health jurisdictions are also active in FASD prevention. Fresno County uses federal Healthy Start funds to identify and intervene in the lives of potentially alcohol dependent women. About half of Fresno County's CPSP providers screen for alcohol abuse using Dr. Ira Chasnoff's 4 P's Plus screening instrument. This brief, nationally-recognized tool identifies pregnant women at risk for alcohol and illicit drugs. Fresno County's Black Infant Health and Nurse Family Partnership programs also screen clients for use of alcohol.

/2007/ In addition to Fresno County, Dr. Chasnoff currently works with the California counties of Ventura, Madera, Alameda, Butte, San Luis Obispo, Humboldt, Riverside, and San Bernardino. Dr. Chasnoff came to Sacramento in February 2006 to present an update on his 4 P’s Plus program to MCAH/OFP Branch staff, local MCAH Directors, and

representatives of the State Office of Women's Health, Department of Rehabilitation, and Department of Social Services. //2007//

/2007/

> High Risk Infants

The CCS Program has structured a system of regional affiliation among the 114 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate quality specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place.

CCS sets standards for all CCS-approved NICUs and periodically conducts NICU site visits to help ensure standards are followed. Included in the standards is a requirement to submit annual morbidity/mortality data to CCS. The CMS Branch began requiring all CCS-approved hospitals to submit CCS NICU annual data through the California Perinatal Quality Care Collaborative (CPQCC) beginning with CY 2004 data. Reporting through the CPQCC facilitates data submission and analysis, provides feedback to the NICUs, and improves reporting accuracy.

Each CCS-approved NICU facility is required to have an organized High-Risk Infant Follow-Up (HRIF) program or a written agreement for the provision of these services by another NICU facility to ensure follow-up. After reviewing functions and responsibilities of the NICU HRIF program and the contractual Medically Vulnerable Infant Program (MVIP), CMS is combining these two programs into one program that addresses the needs of high-risk infants.

In the formative phase of combining the programs, a group of 30 stakeholders was convened and invited to provide input to CMS on ways for delivering services, defining the eligible population, defining data collection elements, and evaluating the outcomes of the program. The newly formed HRIF program will begin July 1, 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs and the NICUs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates.

//2007//

B. Agency Capacity

The programs of the MCAH/OFP and CMS Branches have been developed to address the three core public health functions: needs assessment; development of program policies to address needs and improve health outcomes; and assurance of the availability of accessible and appropriate high-quality services. Assuring cultural competence and access

to services in a community-based setting are both important principles of CDHS policy development.

The programs of the MCAH/OFP and CMS Branches include the following:
Adolescent Family Life Program (AFLP)
Adolescent Sibling Pregnancy Prevention Program (ASPPP)
/2007/ ASPPP was eliminated in 2006 due to Title V funding cuts. //2007//
AFLP Management Information System
Adolescent Health Program
Advanced Practice Nursing Program
Battered Women's Shelter Program (BWSP)
Black Infant Health (BIH)
BIH Management Information System
California Children's Services (CCS)
California Diabetes and Pregnancy Program (CDAPP)
California Perinatal Transport Centers
Child Health and Disability Prevention Program (CHDP)
Childhood Injury Prevention Program (CIPP)
Comprehensive Perinatal Services Program (CPSP)
Comprehensive Perinatal Services Provider Training
Family Health Outcomes Project (FHOP) and Local MCAH Data
Family Planning Access Care and Treatment (Family PACT)
Fetal Infant Mortality Review Program (FIMR) and BIH FIMR
Genetically Handicapped Persons Program (GHPP)
Health Care Program for Children in Foster Care (HCPCFC)
Maternal Child and Adolescent Health Program (MCAH)
MCAH in Schools (formerly named School Health Connections)
Medical Therapy Program (MTP)
Medically Vulnerable Infant Program (MVIP)
Newborn Hearing Screening Program (NHSP)
Oral Health
Perinatal Profiles and Improved Perinatal Outcomes Data Reports Website
Regional Perinatal Programs of California (RPPC)
Sudden Infant Death Syndrome (SIDS) Program
Teen Pregnancy Prevention Programs
Youth Pilot Program (YPP) and Integrated Health and Human Services Pilot

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

> Support to local infrastructure

Several system-wide programs, including MCAH, CCS, and CHDP, are administered by local health departments under the direction and guidance of the MCAH/OFP and CMS Branches. In addition to setting statewide policy, the State funds local health departments for these activities.

The Youth Pilot Program (YPP) facilitates integration of CDHS services for youth in six counties. YPP focuses on high-risk, multi-need, low-income youth and their families. The YPP pilots allow counties to make decisions locally regarding the best use of state and local human services funds without a reduction of state and federal funds. YPP was established in 1995 and has been reauthorized through January 2009.

/2007/ Placer County has implemented comprehensive services for the YPP population, and Alameda County is planning to do so in the near future. The other four counties are still in the planning stages. //2007//

> Quality of maternity services

The California Perinatal Quality Care Collaborative (CPQCC) is a cooperative effort of public and private obstetric and neonatal providers, insurers, public health professionals (including MCAH/OFP and CMS), and business groups. It is working to develop an effective perinatal and neonatal quality improvement infrastructure at state, regional, and hospital levels. CPQCC membership has grown to over 100 hospitals and accounts for most newborns requiring critical care in California. Participating hospitals receive an annual online report with comparative analysis on perinatal and neonatal data.

/2007/ CPQCC membership has grown to over 120 hospitals. //2007//

/2007/ CPQCC has developed a quality assurance tool for use by hospitals in evaluating the quality of neonatal services and a CPQCC team visits member hospitals to assist with the process. //2007//

The Perinatal Quality Improvement Panel (PQIP), a subcommittee of CPQCC, recommends quality improvement objectives, provides models for performance improvement, and assists providers in a multi-step transformation of data into improved patient care through the use of toolkits, workshops, and follow-up. MCAH/OFP and CMS staff are members of the CPQCC Executive Committee and PQIP.

The MCAH/OFP Branch recently developed the Maternal Quality Collaborative (MQC), a joint effort with the CPQCC and UCLA's Maternal Quality Indicators group. The MQC Leadership Council includes members from CCS, MCAH/OFP, MCMC, and Medi-Cal Policy Section. The MQC will direct statewide maternal quality improvement activities utilizing the methodology developed by the CPQCC.

CDAPP works to promote optimal management of diabetes in at-risk women, before, during and after pregnancy. CDAPP has care guidelines which address everything from lab values to billing and data issues.

> Infants' access to care

Medi-Cal, Healthy Families (HF) and Access for Infants and Mothers (AIM) provide health insurance coverage for infants. Medi-Cal reaches infants living in households with incomes below 200 percent of FPL. HF provides insurance coverage for infants in households with incomes up to 250 percent of the FPL; monthly premiums and copayments for certain types of visits and prescriptions are required. AIM provides state-subsidized third party insurance for infants in households with incomes between 200 and 300 percent of FPL.

/2007/ Preventive screening and basic health services are provided to infants under a year of age by the CHDP program. In FY 2003-04, 555,953 infants under one year of age received health services through CHDP. This was a 5 percent increase from the prior year. Of these infants, 75 percent had Medi-Cal coverage and 25 percent were state-funded

(compared with 64 percent and 36 percent in FY 2002-03). This large increase in Medi-Cal coverage is most likely due to the CHDP Gateway and infant deeming. The largest ethnic group is again Hispanic (68 percent compared with 66 percent FY 2002-03). //2007//

> Infant Health Promotion

CDHS promotes exclusive breastfeeding initiation at birth and prolonging breastfeeding during infancy. Breastfeeding is promoted across all MCAH/OFP programs serving pregnant women and infants. Informational materials regarding breastfeeding, nutrition and immunizations for women, adolescents, children, and infants, are regularly disseminated to AFLP, BIH, CPSP, and RPPC providers. The CDAPP Guidelines for Care include a chapter on breastfeeding. The MCAH/OFP website includes a page devoted to breastfeeding. The page includes data on postpartum hospital breastfeeding discharge rates, local breastfeeding coalitions, links to other breastfeeding resources, and model breastfeeding policies. MCAH/OFP also offers technical assistance to hospitals to improve their breastfeeding policies.

Birth defects remain the number one cause of infant deaths. While the causes of many congenital defects have yet to be identified, effective measures for the prevention of a significant portion of neural tube defects are known. MCAH/OFP Branch activities focus on folic acid promotion during the preconception and prenatal periods to reduce the risk of neural tube defect-affected pregnancies. The MCAH/OFP Branch is an active participant in the National Council on Folic Acid.

The Genetic Disease Branch (GDB) of CDHS provides newborn screening for primary hypothyroidism, phenylketonuria (PKU), galactosemia, sickle cell disease and other hemoglobinopathies to 99 percent of the newborn population. The Newborn Screening (NBS) Program is expanding to include over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS), and classical congenital adrenal hyperplasia. CMS is working with the GDB to inform CCS-approved Special Care Centers (SCCs) and CCS County and Regional Offices of the expansion and to enlist their help in expediting referrals for infants with positive screening test results. The CCS program is authorizing the appropriate SCC for diagnostic evaluations for all infants referred by the NBS program. This combined program effort is imperative to ensure early diagnosis to avoid serious disabilities and even death in some cases.

/2007/ On July 1, 2005, the Newborn Screening (NBS) Program expanded to include classical congenital adrenal hyperplasia (CAH) and over 40 additional metabolic conditions detectable via Tandem Mass Spectrometry (MS/MS). From July 1, 2005 to December 31, 2005, 273,982 infants were screened. There were 533 positive screens for CAH and 14 cases diagnosed. There were 656 positive screens from MS/MS and 58 cases diagnosed of inborn errors (including PKU). //2007//

Several programs of the MCAH/OFP Branch address additional causes of infant mortality and morbidity. The SIDS Program has facilitated the SIDS Risk Reduction campaign, also known as Back to Sleep (BTS) in California. The rate of death due to SIDS in California declined from 94.5 per 100,000 live births in 1992 to 32.3 in 2003.

/2007/ Between 1999 and 2004 the rate of infant deaths due to SIDS in California declined 31.4 percent, from 45.7 per 100,000 live births to 31.4 per 100,000 live births. In 2004

African American infants had the highest rate of SIDS at 83.7 per 100,000 live births, followed by 40.2 for White/Other infants and 23.6 for Hispanic infants. //2007//

The Black Infant Health (BIH) Program has the goal of reducing African-American infant mortality in California. BIH funds programs in 17 local health jurisdictions, which, combined, account for 94 percent of the state's African American births.

California's Fetal Infant Mortality Review (FIMR) Program, which took a significant budget cut in FY 2002-03, was expanded this year, with a $250,000 reallocation of Title V funds. This new funding has established the Black Infant Health FIMR (BIH/FIMR) Program. The goal of the BIH/FIMR program is to reduce African American fetal and infant deaths through review of these deaths at the community level. Eight of the seventeen FIMR jurisdictions with the greatest proportion of African American births have been selected for participation.

The MCAH/OFP Branch prepared a grant application to CDC for a Fetal Alcohol Syndrome Program, but it was not funded. MCAH/OFP continues to network with counties that are addressing Fetal Alcohol Spectrum Disorder (FASD).

There are 176 hospitals certified and participating in the Newborn Hearing Screening Program as of March 2005, up from 159 one year ago. During CY 2004, over 370,000 infants received hearing screening prior to hospital discharge. Only 6 percent of infants who needed additional evaluation after hospital discharge were lost to follow-up (compared to 30-50 percent in other states).

/2007/ As of March 2006 there were 177 hospitals certified and participating in the Newborn Hearing Screening Program (NHSP). During CY 2005, over 385,000 infants received hearing screening prior to hospital discharge. During CY 2004, 699 infants were identified with hearing loss, an incidence rate of 1.9 per 1000. Among NICU infants, the incidence of hearing loss was 7.5 per 1000. //2007//

Preventive and Primary Care for Children

> Access to care

Medi-Cal and HF provide access to a comprehensive package of primary and preventive services, including dental care, for California's low-income children. Medi-Cal covers children ages 1 through 5 up to 133 percent of FPL, children and adolescents ages 6 up to 19 at up to 100 percent of FPL, and young adults ages 19 to 21 at up to 86-92 percent of FPL. HF covers children from 0 through 18 years of age who are uninsured and living in households with incomes up to 250 percent of FPL. Monthly premiums and copayments for certain types of visits and prescriptions are required. There were 697,305 children enrolled in HF as of December 2004. This is a 2 percent increase from December 2003 and a 24 percent increase from March 2002.

/2007/ As of December 2005, there were 742,325 children enrolled in HF. This is a 6.5 percent increase from December 2004. //2007//

The CMS Branch administers the screening component of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) entitled the CHDP program. CHDP provides preventive services, including health assessments, immunizations, screening tests, dental screening, anticipatory guidance, health education, and referral for further diagnosis and

treatment for Medi-Cal-funded children up to 21 years of age. Uninsured children and youth up to 19 years of age in families with incomes at or below 200 percent of the FPL are eligible to pre-enroll in Medi-Cal through the Gateway process.

In FY 2002-03, 2,114,480 children received screening and health assessments through the CHDP program, a 1.3 percent increase from FY 2001-02.

/2007/ In FY 2003-04, 2,065,237children received screening and health assessments through the CHDP program, a 2 percent decrease from FY 2002-03. Of the over 2 million children receiving CHDP services, 80 percent were funded by Medi-Cal and 20 percent were funded through state funds, compared with 60 percent and 40 percent, respectively, for 2002-03. This shift into Medi-Cal is most likely due to the CHDP Gateway. //2007//

The CHDP Gateway, implemented in July 2003, has pre-enrolled 1.2 million children through February 2005, and 80 percent of them have requested a joint Medi-Cal/HF application. CDHS has modified the pre-enrollment process that allows the Gateway transaction to identify and "deem" certain infants less than one year of age as eligible for ongoing, full-scope, no cost Medi-Cal at the time of a CHDP health assessment. The families of these infants do not have to complete a Medi-Cal application. Through this process, 42,837 infants were enrolled in Medi-Cal through February 2005.

/2007/ Through February 2006 the CHDP Gateway has pre-enrolled over 1.9 million children, and 70 percent of them have requested a joint Medi-Cal/HF application. Through this process, 102,449 infants were enrolled in Medi-Cal through February 2006. //2007//

> Childhood/adolescent health promotion

Injuries are the leading cause of mortality among children and youth. To reduce injury-related mortality and morbidity among children and adolescents, MCAH/OFP contracts with the Center for Injury Prevention Policy and Practice (CIPPP) at San Diego State University (SDSU). CIPPP provides technical assistance and training for local MCAH programs through conferences, a list serve, and weekly literature reviews of the latest injury prevention research. The MCAH/OFP Branch continues to fund five local MCAH jurisdictions to increase injury prevention capacity within their community.

/2007/ Due to Title V budget cuts, funding for the MCAH/OFP contract with CIPPP has been reduced. The reduction eliminates funding for the annual statewide conference and reduces technical assistance provided to local health jurisdictions. //2007//

As a part of the California Initiative to Improve Adolescent Health by the Year 2010, the National Adolescent Health Information Center (NAHIC) and the California Adolescent Health Collaborative (AHC) continue to provide support to local jurisdictions interested in adolescent health. During last fiscal year, the Guide to Adolescent Health Data Sources was produced to assist locals who were interested in adolescent health to better assess the needs of the youth in their community. NAHIC and AHC provide technical assistance to assist local programs in developing a grant application template that they can use for future applications to foundations and federal agencies. The California AHC also puts out an annual report card on key adolescent health indicators.

The MCAH/OFP Branch applied for a System Capacity for Adolescent Health Technical Assistance Grant from the Association of Maternal and Child Health Programs (AMCHP),

but did not receive one. In spite of this, California hopes to continue to assess and improve adolescent health system capacity in the State.

The MCAH/OFP Branch held an Adolescent Health System Capacity Assessment stakeholder meeting in April 2005, in addition to local feedback meetings with MCAH Directors, AFLP regional representatives, and TPP grantees. Preliminary results of these meetings reveal that there is a great need to increase efforts in general adolescent health at the MCAH/OFP Branch and increase partnerships especially in the areas of mental health, education, substance abuse, and juvenile justice. In addition, the local jurisdictions want to see more state staff attending local events and visiting programs so that stronger partnerships between state and local programs can be fostered. Local jurisdictions also expressed a strong need for more financial and human resources for adolescent health so that they could implement California's adolescent health strategic plan at the local level. In general, participants expressed a desire to have a more comprehensive, integrated, dedicated focus on adolescent health at the MCAH/OFP Branch. MCAH/OFP staff will use the information from these meetings to plan ways to better serve our local constituents in the coming years.

/2007/ Due to Title V budget cuts, the contract with AHC for adolescent health improvement has been eliminated. Technical assistance will no longer be provided to local health jurisdictions planning and implementing the recommendations provided by the Adolescent Health Improvement plan. //2007//

The MCAH/OFP Branch participates in the multi-agency California Coalition for Youth Development. The coalition serves to improve youth development throughout California through the annual Youth Development Summit and other projects. Participants include the Attorney General's Office, CDE, 4-H Center for Youth Development, Friday Night Live, Alcohol and Drug Program, and the Department of Mental Health (DMH).

/2007/ MCAH/OFP has received a multi-year grant beginning in 2003 from the federal Health Resources and Services Administration (HRSA) for the State Early Childhood Comprehensive Systems (SECCS) project. MCAH/OFP provides state-level leadership for early childhood health programs to help California's children be emotionally, socially, and physically ready for kindergarten. Two years of planning culminated in a statewide needs assessment and strategic plan to address critical components of early childhood health care systems. The project is now in the implementation phase. //2007//

The MCAH/OFP Branch participates in UCSF's Childcare Health Program Advisory Committee. This organization is dedicated to enhancing the quality of childcare for California's children by initiating and strengthening linkages between health, safety, and child care communities and the families they serve. This program previously received the Healthy Child Care America (HCCA) Grant, which has now been folded into the SECCS grant. UCSF's HCCA director serves as the co-director for the SECCS grant.

The CMS Branch continues to participate in the Childhood Asthma Initiative through the CAI CHDP project, consisting of asthma education, trainings, resource development, and implementation of Asthma Assessment Guidelines for CHDP providers. Through this project, which ends in June 2005, some local CHDP programs have established or become active in local asthma coalitions, and other programs have expanded their asthma community outreach.

/2007/ The Childhood Asthma Initiative grant ended July 2005. //2007//

The MCAH/OFP Branch continues to participate in the California Interagency Asthma Interest Workgroup, a collaborative that includes CDHS, CDE, First Five California, and the California Environmental Protection Agency. This group serves as a forum for collaboration in addressing asthma in California.

> Services for Children with Special Health Care Needs (CSHCN)

The CMS Branch administers the CCS program that provides case management and payment of services for CSHCN. The program authorizes medical and dental services related to the CCS eligible condition. Additionally, it establishes standards for providers, hospitals, and Special Care Centers (SCC) for the delivery of care in tertiary medical settings and in local communities, and provides physical and occupational therapy and medical case conference services at selected public school sites for children with specific medically eligible conditions.

/2007/ The CCS Medical Therapy Program (MTP) provides physical and occupational therapy services to children with CCS MTP eligible conditions. There is no financial eligibility requirement. The number of clients enrolled in the MTP has remained fairly stable for the past four years and is currently 26,698. //2007//

/2007/ The estimated caseload for CCS in Federal Fiscal Year (FFY) 2004-2005 was 175,930. This is a two percent increase from the prior year of 172,510. Approximately 81 percent of these children were enrolled in Medi-Cal, 11 percent were enrolled in HF and 8 percent were enrolled in state-only CCS. CHDP providers continue to facilitate referrals to CCS of children with CCS eligible or potentially CCS eligible conditions. //2007//

The CCS program is responsible for case managing the care of the CCS eligible condition for Medi-Cal beneficiaries and authorizes Medi-Cal reimbursement for services related to the CCS condition, including EPSDT supplemental services. CCS case manages and authorizes payment of services related to the CCS eligible condition for children enrolled in HF. Through a system of CCS-approved SCCs, CCS provides access to quality specialty and subspecialty providers for CSHCN. The SCCs are located in the outpatient departments of tertiary care hospitals and use multidisciplinary teams to address health needs and provide coordinated care for CCS beneficiaries.

Thirty-one "independent" counties fully administer their own CCS programs, and 27 "dependent" counties share the administrative and case management activities with CMS Branch Regional Offices. The Case Management Improvement Project has encouraged dependent counties to assume case management functions historically done by state Regional Office staff.

The CCS Program has structured a system of regional affiliation among the 121 CCS-approved neonatal intensive care units (NICUs) to assure that infants have access to appropriate specialty consultation and intensive care services throughout the state. CCS-approved NICUs are designated as Intermediate, Community, and Regional NICUs. NICUs that provide basic level intensive care services to infants in their communities are required to have established affiliations with NICUs that provide more extensive services, to facilitate consultation and patient transfers as needed. The CCS approval process denotes the level of patient care provided in each NICU and verifies that the cooperative agreements are in place. In June 2001 the CPQCC initiated annual NICU data reporting to CCS. Annual NICU

reporting is required for continuing CCS approval and reporting through the CPQCC facilitates data submission and analysis and improves reporting accuracy. The CMS Branch is requiring all CCS-approved hospitals to submit CCS NICU annual data through CPQCC beginning with CY 2004 data.

/2007/ The number of CCS-approved NICUs is currently 114. //2007//

The CMS Branch has two programs that address the needs of high-risk infants. The first allows infants that are discharged from CCS-approved NICUs to be followed in NICU High Risk Infant Follow-up clinics. Three multidisciplinary outpatient visits are authorized by CCS during the first three years of life to identify problems, institute referrals, and monitor outcomes. Visits include a comprehensive history and physical examination, developmental testing, and ophthalmologic, audiologic, and family psychosocial evaluations.

The second program, the Medically Vulnerable Infant Program (MVIP), has used a network of community-based contractors to provide home-based services to high-risk infants from NICUs and their families. Services have been provided to infants up to three years of age. Twelve contractors, including hospitals, community-based organizations and universities, have contracts until December 2005. As of March 2005, 4,282 infants have been enrolled in the program and 51,280 home visits have been made since program inception July 2000.

/2007/ After reviewing functions and responsibilities of the NICU High Risk Infant Follow-up (HRIF) program and the MVIP, CMS is combining these two programs into one program that addresses the needs of high-risk infants. The newly formed HRIF program will begin in July 2006, building upon the NICU HRIF programs already in place throughout the state. CMS is working with CPQCC to build upon the data that all CCS approved NICUs currently submit. The ability to collect expanded data elements will give the HRIF programs the opportunity to evaluate the outcomes of their NICU high-risk infant graduates. //2007//

The Genetically Handicapped Persons Program (GHPP) provides case management and funding for medically necessary services for people with certain genetic conditions. Most GHPP clients served in this program are adults, but 10 percent are children under 21 years. The GHPP serves eligible children with higher family incomes that make them ineligible for the CCS program. There are currently 1,563 clients enrolled in GHPP. The decline from 1,690 clients last year is primarily due to closing inactive cases. Hemophilia is the most common GHPP diagnosis followed by cystic fibrosis, sickle cell disease, Huntington's Disease, and Friedreich's Ataxia.

/2007/ There are currently 1,550 clients enrolled in GHPP, stable from the prior year. //2007//

> Rehabilitation services to Supplemental Security Income (SSI) beneficiaries under the age of 16

SSI beneficiaries with a CCS medically-eligible diagnosis are served by the CCS program. During FY 2003-04, CCS received 2,057 referrals of SSI beneficiaries, and 52 percent of these were medically eligible for the CCS program. If physical and/or occupational therapy are needed, they can be provided in the CCS MTP. Children receiving SSI who have mental or developmental conditions are served by DMH, Department of Developmental Services (DDS), and CDE.

/2007/ During FY 2004-05, CCS received 550 referrals of SSI beneficiaries, and 46 percent of these were medically eligible for the CCS program. //2007//

> Family-centered, community-based coordinated care for CSHCN

SCCs and hospitals that treat CSHCN and wish to become CCS-approved must meet specific criteria for approval. One of the criteria used in evaluation involves provision of family-centered care (FCC). During the facility review, FCC is assessed and, as part of the review, the CMS Branch sends a follow-up report to the facility with FCC recommendations.

The CCS program facilitates FCC services for families of CSHCN. CCS staffing standards allow a parent liaison position in each county CCS program to enable FCC. County programs assist families in accessing authorized services. Many families live long distances from the site of appropriate pediatric specialty and subspecialty care. The program provides reimbursement for travel expenses (gas, bus tickets, taxis), meals for extended stays, and motel rooms for families when there are extended hospital stays.

The Children's Regional Integrated Service Systems (CRISS) (a collaboration of family support organizations, pediatric providers, statewide organizations, 14 county CCS programs in Northern California, and Family Voices of California) has a FCC Work Group that meets bimonthly. This group plans, develops and sponsors an annual fall conference (in addition to assisting with other conferences, workshops, resource fairs, and addressing issues regarding FCC); the conference for 2004 was about sexuality and youth with disabilities.

/2007/ The conference for 2005 was entitled, “What Happens at 18? Conservatorship and Other Legal Rights for the CCS Client.” Youth and their parents, educators working on transition teams, Regional Center staff, CCS staff, family support agency staff, parent leaders, and public agency staff participated. //2007//

The CMS Branch has been directing a Champions for Progress Center Incentive Award that has involved convening a group of key stakeholders, with past investments in and knowledge of the system of care for CSHCN and their families to meet bimonthly for twelve months to develop strategies and an action plan to address the CSHCN Title V performance measures and prioritized issues resulting from the Title V Needs Assessment process. The project is building on existing coalitions and projects as well as past efforts to develop a long-term, strategic plan for serving CSHCN; it is identifying resources within California to carry out the activities defined in the strategic plan. /2007/ There have been 25-30 stakeholders consistently participating in these monthly meetings. //2007//

A federal Maternal and Child Health Bureau (MCHB) grant has been awarded to the University Affiliated Program at University of Southern California/Children's Hospital Los Angeles (CHLA), collaborating with CRISS and Family Voices of California, for a 3-year project to implement integrated community systems of care for CSHCN. /2007/ The collaboration with CMS will promote implementation statewide and regionally of the strategies from the Champions Award stakeholder process. The Champions stakeholder group will meet on a quarterly basis to review and comment on implementation progress through June 2008. //2007//

CCS is collaborating with CHLA and the CA Epilepsy Foundation on a grant from HRSA for Improving Access to Care for Children and Youth with Epilepsy. The overall goal of the

project is to improve access to health and other services and to facilitate the development of state-wide community-based interagency models of comprehensive, family-centered, culturally-effective care and state-wide standards of care.

LA County CCS produced a "Handbook for Los Angeles County CCS Families" in English and Spanish after working for two years with low-income, English and Spanish-speaking parents; 13 Family Resource Centers; TASK (Team of Advocates for Kids); providers; Regional Centers; and LA CMS staff.

> Transitioning services for CSHCN

The CMS Branch recognizes the importance of transitioning care for CSHCN from pediatric to adult services. During site reviews of new SCCs and county CCS programs, transition issues are emphasized as important for the future delivery of medical care and services to the CSHCN.

CCS staff in Southern California regularly attend and participate with the Special Education Local Planning Areas (SELPA) Interagency Coordinating Transition Council. Transition committees in local county CCS programs receive input from parents and young adult clients to assess and develop ways to infuse the concept of transition into CCS services and functions. At the bimonthly meetings of the CRISS FCC Work Group, county CCS programs report on transition activities. A matrix of transition activities of each of the 14 counties represented is maintained and updated. The CMS Branch is contracting with CRISS to provide raw and analyzed data (from a survey) regarding statewide CCS program FCC and transition activities.

/2007/ 52 of 58 counties have responded to the survey reporting on their FCC and transition activities. The results will be analyzed over the coming months.

/2007/ CHLA, UCLA Child and Family Health Program, LA Partnership for Special Needs Children, CRISS, CCS, and CMS Branch are collaborating on a conference entitled “Family-Centered Strategies for Effective Transition for Youth with Special Health Care Needs: A Training for Providers and Families” in April 2006 in Los Angeles. Experts in the field will provide information to agency staff, providers, youth and their families about the system of care for transitioning youth, transition resources, and strategies for assisting youth and their families. //2007//

The CMS Branch formed a transition workgroup that has begun meeting and will ultimately develop transition policy and guidelines for the CCS program. There are healthcare professionals, experts in transitioning care, and family representatives.

/2007/ The transition workgroup has completed a survey that is being sent to county and Regional Office CCS programs to better understand what local and state CCS programs are doing to foster transition services and what the needs are for transition resources, technical assistance and training. This workgroup will also be reviewing the transition strategies from the Champions stakeholder group to help determine an implementation plan for these strategies. //2007//

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National and State Performance and Outcome Measures and Health System Capacity Indicators

NOTE: The reporting year for the Federal Fiscal Year 2006-2007 Title V Block Grant Application/Annual Report is 2005. The 2005 data shown in italics below are provisional data based on 2004 final data. Proposed annual objectives in this report are for the 2006-2010 time period. This year's Title V Block Grant Application/Report guidance changed three National Performance Measures. New State Performance Measures have been added by the CMS Branch and the MCAH/OFP Branch.

California Title V *National* Performance Measures

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
1.	Percent of infants who are screened for conditions mandated by their State-sponsored newborn screening programs (e.g., phenylketonuria and hemoglobinopathies) and receive appropriate follow-up and referral as defined by their State.	2001 2002 2003 2004 *2005*	98.4 98.7 99.5 100.0 *100.0*	2001 2002 2003 2004 2005 2006-2010	- 99.0 99.0 99.0 99.5 100
2.	The percent of children with special health care needs age 0 to 18 whose families partner in decision-making at all levels and are satisfied with the services they receive. a) National Survey of Children with Special Health Care Needs (CSHCN)	2002 2003 2004 2005	47.6[a] 47.6 [a] 47.6 [a] 47.6 [a]	- 2003 2004 2005 2006 2007 2008-2010	- 48.5 49.5 50.5 51.5 52.5 53.5
3.	The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. a) CSHCN Survey	2000 2001 2002 2003 2004 2005	23.8 33.4 44.7[a] 44.7[a] 44.7[a] 44.7[a]	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	35.0 25.0 30.0 45.5 46.5 48.0 50.0 51.0 52.0 53.0 54.0
4.	The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. a) CSHCN Survey	2000 2001 2002 2003 2004 2005	97.7 97.0 59.3 [a] 59.3 [a] 59.3 [a] 59.3 [a]	2000 2001 2002 2003 2004 2005 2006 2007 2008-2010	96.5 97.7 98.0 60.5 62.5 64.5 66.5 68.5 70.5

* Data is either being analyzed or unavailable at the time of report

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
5.	The percent of children with special health care needs age 0 to 18 whose families report the community-based service system are organized so they can use them easily. [a] CSHCN Survey	2002 2003 2004 2005	65.9 [a] 65.9 [a] 65.9 [a] 65.9 [a]	- 2003 2004 2005 2006 2007 2008-2010	- 67.0 68.0 69.0 70.0 71.0 72.0
6.	The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life. [a] National data; sample size too small for CA, therefore no state objective at this time	2002 2003 2004 2005	5.8 [a] 5.8 [a] 5.8 [a] 5.8 [a]	- 2003 2004 2005 2006 2007 2008 2009 2010	- - - - - - - - -
7.	Percent of children age 19 to 35 months who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B. [a] Based on 4:3:1:3:3 series. Prior data based on 4:3:1:3 series.	2000 2001 2002 2003 2004 *2005*	75.3[a] 74.9 [a] 75.8 [a] 77.4 [a] 81.3 [a] *81.3* [a]	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	76.0 76.4 75.4 75.8 75.8 78.0 82.0 82.7 83.4 84.1 84.8
8	The birth rate (per 1,000 females) for teenagers aged 15 through 17 years.	2000 2001 2002 2003 2004 *2005*	26.6 23.8 22.4 21.1 20.6 *20.6*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	28.7 25.0 23.5 22.3 21.9 20.0 20.1 19.6 19.1 18.6 18.1
9.	Percent of third grade children who have received protective sealants on at least one permanent molar tooth. [a] New data source based on Oral Health Needs Assessment Survey. 2003 data based on preliminary survey results.	2000 2001 2002 2003 2004 2005	18.7 19.5 19.7 31.0[a] 27.6[a] 27.6 [a]	2000 2001 2002 2003 2004 2005 2006-2010	19.6 18.7 19.5 19.9 20.2 31.0 27.6

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
10	The rate of deaths to children aged 14 and younger caused by motor vehicle crashes per 100,000 children.	2000 2001 2002 2003 2004 *2005*	2.9 3.1 2.9 3.6 3.1 *3.1*	2000 2001 2002 2003 2004 2005 2006-2007 2008-2009 2010	2.7 2.6 2.8 2.6 2.6 2.9 3.0 2.9 2.8
11	Percentage of mothers who breastfeed their infants at 6 months of age. (New National Performance Measure) [a)] Percent of mothers breastfeeding at 2 months of age reported from the California Maternal and Infant Health Assessment (MIHA) Survey.	2004 *2005*	69.1[a] *69.1*[a]	2004 2005 2006 2007 2008 2009 2010	- - 69.6 70.1 70.6 71.1 71.6
11	~~Percentage of mothers who breastfeed their infants at hospital discharge.~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~42.9~~ ~~42.6~~ ~~42.2~~ ~~41.8~~ ~~41.2~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004~~ ~~2005~~ ~~2006~~ ~~2007~~ ~~2008~~ ~~2009~~	~~44.0~~ ~~44.1~~ ~~44.8~~ ~~43.1~~ ~~44.0~~ ~~41.5~~ ~~41.7~~ ~~42.2~~ ~~42.7~~ ~~43.2~~ ~~43.7~~
12	Percentage of newborns that have been screened for hearing impairment before hospital discharge.	2000 2001 2002 2003 2004	13.7 21.6 52.2 56.2 68.6	2000 2001 2002 2003 2004 2005 2006-2010	10.0 15.0 40.0 60.0 70.0 70.0 75.0

California Title V *National* Performance Measures (continued)

National Performance Measure		*Year*	*Measure*	*Year*	*Objective*
13.	Percent of children without health insurance.	2000 2001 2002 2003 2004 *2005*	15.7 15.3 14.3 13.1 13.1 *13.1*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	18.0 16.2 16.7 15.5 15.5 12.9 13.0 12.9 12.8 12.7 12.6
14.	Percent of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile. (New National Performance Measure)	2004 *2005*	33.8 *33.8*	2004 2005 2006-2007 2008-2009 2010	- - 33.7 33.6 33.5
14.	~~Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program.~~ (Moved to Health System Capacity Indicator 7A)	~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~60.8~~ ~~60.9~~ ~~61.7~~ ~~70.9~~	~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004-2009~~	~~63.6~~ ~~60.3~~ ~~60.3~~ ~~59.6~~ ~~*~~
15.	Percent of women who smoke in the last three months of pregnancy. (New National Performance Measure)	2004 *2005*	3.5 *3.5*	2004 2005 2006 2007 2008 2009 2010	- - 3.4 3.3 3.2 3.1 3.0
15.	~~Percent of very low birth weight live births.~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~	~~1.1~~ ~~1.1~~ ~~1.1~~ ~~1.2~~ ~~1.2~~	~~1999~~ ~~2000~~ ~~2001~~ ~~2002~~ ~~2003~~ ~~2004-2009~~	~~1.2~~ ~~1.2~~ ~~1.2~~ ~~1.1~~ ~~1.1~~ ~~1.2~~

* Data is either being analyzed or unavailable at the time of report

California Title V *National* Performance Measures (continued)

	National Performance Measure	*Year*	*Measure*	*Year*	*Objective*
16.	The rate (per 100,000) of suicide deaths among youths 15-19.	2000 2001 2002 2003 2004 *2005*	5.2 4.9 4.7 5.0 5.7 *5.7*	2000 2001 2002 2003 2004 2005 2006-2010	4.2 5.9 5.4 4.7 4.6 4.8 5.6
17.	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.	2000 2001 2002 2003 2004 *2005*	65.9 65.6 68.7 67.3 68.0 *68.0*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	66.4 66.5 66.6 68.7 69.6 68.5 68.2 68.4 68.6 68.8 69.0
18.	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.	2000 2001 2002 2003 2004 *2005*	84.5 85.4 86.5 87.3 87.1 *87.1*	2000 2001 2002 2003 2004 2005 2006-2010	84.5 85.0 85.9 87.4 88.4 89.4 87.1

California Title V *State* Performance Measures

	State Performance Measures	*Year*	*Measure*	*Year*	*Objective*
1.	The percent of children birth to 21 years enrolled in the California Children Services (CCS) program who have a designated medical home.	2006	57.9	2006 2007 2008 2009 2010	50.0 51.0 52.0 53.0 54.0
2.	The ratio of pediatric cardiologists authorized by the CCS program to children birth through 14 years of age receiving cardiology services from these pediatric cardiologists.	2006	*	2006	*
3.	The percent of women who reported 14 or more not good mental health days in the past 30 days (frequent mental distress).	2004 *2005*	13.7 *13.7*	2004 2005 2006-2010	- - 13.6
4.	The percent of women who reported drinking any alcohol in the first or last trimester of pregnancy.	2004 *2005*	16.5 *16.5*	2004 2005 2006-2010	- - 16.4
5.	The rate of deaths per 100,000 adolescents aged 15 through 19 years caused by motor vehicle injuries.	2000 2001 2002 2003 2004 *2005*	12.9 17.3 20.1 19.7 18.4 *18.4*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	13.2 12.2 16.0 20.7 20.7 19.5 18.2 18.0 17.8 17.6 17.4
6.	The incidence of neural tube defects (NTDs) per 10,000 live births plus fetal deaths among counties participating in the California Birth Defects Monitoring System.	2000 2001 2002 2003 2004 *2005*	7.3 5.4 7.7 7.7 5.2 *5.2*	2000 2001 2002 2003 2004 2005 2006-2010	4.6 6.7 6.5 7.0 7.0 7.0 5.2
7.	The percent of newly referred clients to the CCS program whose cases are opened within 30 days of referral.	2004	*	2004	*
8.	The percent of births resulting from unintended pregnancy.	2004 *2005*	42.4 *42.4*	2004 2005 2006 2007 2008 2009 2010	- - 42.1 41.8 41.5 41.2 40.9

California Title V *State* Performance Measures (continued)

	State Performance Measures	*Year*	*Measure*	*Year*	*Objective*
9.	The percent of 9th grade students who are not within the Healthy Fitness Zone for Body Composition.	2004 *2005*	32.9 *32.9*	2004 2005 2006 2007 2008 2009 2010	- - 32.8 32.7 32.6 32.5 32.4
10.	The percent of women 18 years or older reporting intimate partner physical, sexual, or psychological abuse in the past 12 months.	2004 *2005*	9.7 *9.7*	2004 2005 2006 2007 2008 2009 2010	- - 9.6 9.5 9.4 9.3 9.2

* Data is either being analyzed or unavailable at the time of report.

California Title V *National* Outcome Measures

	National Outcome Measures	*Year*	*Measure*	*Year*	*Objective*
1	The infant mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 *2005*	5.4 5.3 5.4 5.2 5.2 *5.2*	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	5.3 5.2 5.2 5.4 5.4 5.2 5.1 5.0
2	The ratio of the black infant mortality rate to the white infant mortality rate.	2000 2001 2002 2003 2004 *2005*	2.7 2.6 2.5 2.7 2.6 *2.6*	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	2.6 2.7 2.6 2.4 2.4 2.6 2.5 2.4
3	The neonatal mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 *2005*	3.6 3.5 3.6 3.5 3.5 *3.5*	2000 2001 2002 2003 2004 2005 2006-2007 2008-2010	3.5 3.5 3.5 3.5 3.5 3.5 3.5 3.4
4	The post neonatal mortality rate per 1,000 live births.	2000 2001 2002 2003 2004 *2005*	1.7 1.8 1.8 1.7 1.7 *1.7*	2000 2001 2002 2003 2004 2005 2006-2010	1.7 1.7 1.7 1.7 1.7 1.6 1.6
5.	The Perinatal mortality rate ((deaths: fetal and infant/fetal deaths and live births) *1,000)).	2000 2001 2002 2003 2004 *2005*	5.9 5.6 5.7 5.5 5.5 *5.5*	2000 2001 2002 2003 2004 2005 2006-2008 2009-2010	8.0 7.9 5.5 5.6 5.6 5.5 5.4 5.3

California Title V *National* Outcome Measures (continued)

National Outcome Measures		*Year*	*Measure*	*Year*	*Objective*
6.	The child death rate per 100,000 children aged 1 through 14.	2000	19.2	2000	16.4
		2001	17.9	2001	16.9
		2002	17.8	2002	16.2
		2003	18.8	2003	16.2
		2004	17.2	2004	16.0
		2005	*17.2*	2005	18.4
				2006	17.2
				2007-2008	17.0
				2009-2010	16.8

California Title V *State* Outcome Measures

	State Outcome Measure	*Year*	*Measure*	*Year*	*Objective*
1	The maternal mortality rate per 100,000 live births.	2000 2001 2002 2003 2004 *2005*	11.1 10.2 10.6 15.2 13.6 *13.6*	2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010	8.0 7.3 7.8 10.4 10.3 11.6 13.3 13.0 12.7 12.4 12.1

	Health System Capacity Indicators	*Year*	*Indicator*
1	The rate per 10,000 for asthma hospitalizations among children less than five years old.	2000 2001 2002 2003 2004 *2005*	34.3 33.4 34.7 32.6 30.6 *30.6*
2	The percent of Medicaid enrollees whose age is less than one year during the reporting year that received at least one initial periodic screen. a) New methodology state MediCal program enrollees under one year of age.	1999 2000 2001 2002 2003 2004	72.1 66.0[a] 70.8[a] 66.2[a] 67.3[a] 66.3[a]
3	The percent of Children's Health Insurance Program (CHIP) enrollees whose age is less than one year during the reporting year that received at least one periodic screen.		NA
4	The percent of women (15 through 44) with a live birth during the year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.	2000 2001 2002 2003 2004 *2005*	76.3 76.6 77.8 78.7 78.5 *78.5*

	Health System Capacity Indicator 5: Medicaid and Non-Medicaid Comparison	*Year*	*Indicator*
5A.	Percent of low birth weight (<2,500 grams): Payment source from birth certificate.	2004 2004 2004	6.8(Medic) 6.6(N-Med) 6.7(All)
5B.	Infant deaths per 1,000 live births: matching data files. *2003 data are not currently available	2003 2003 2003	*(Medic) * (N-Med) * (All)

Health System Capacity Indicator 5: Medicaid and Non-Medicaid Comparison (continued)			*Year*	*Indicator*	
5C	Percent of pregnant women entering care in the first trimester: Payment source from birth certificate		2004 2004 2004	82.0(Medic) 91.2(N-Med) 87.1(All)	
5D	Percent of women with adequate (observed to expected prenatal visits is greater or equal to 80% (Kotelchuck Index) prenatal care.		2004 2004 2004	75.7(Medic) 80.7(N-Med) 78.5(All)	
Health System Capacity Indicator 6: Medicaid and CHIP Eligibility Levels			*Year*	*Indicator*	
6A	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for infants.	(Age 0-1)	2004	Medi 200	CHIP 250
6B	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for children.	(Ages 1-5) (Ages 6-19)	2004 2004	133 100	250 250
6C	The percent of poverty for eligibility in the State's Medicaid and CHIP programs for pregnant women		2004	200	-
Health System Capacity Indicators			*Year*	*Indicator*	
7A	Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid program. (Previously National Performance Measure 14) a) New methodology.		2000 2001 2002 2003 2004 *2005*	60.8 60.9 61.7 70.9 90.0[a] *90.0*[a]	
7B	The percent of EPSDT eligible children aged 6 through 9 years who have received any dental service during the year. a) New methodology.		1999 2000 2001 2002 2003 2004	43.8[a] 44.6 45.5 48.1 35.5[a] *	
8	The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program. a) New methodology. b) Figures are not comparable because of another change in methodology.		1999 2000 2001 2002 2003 2004 2005	28.5 26.9 27.0 23.0[a] 22.6[a] 10.9[b] 8.7	

* Data was unavailable at the time of the report.

Health Status Indicators		*Year*	*Indicator*
1A	The percent of live births weighing less than 2,500 grams	2000 2001 2002 2003 2004 *2005*	6.2 6.3 6.4 6.6 6.7 *6.7*
1B	The percent of live singleton births weighing less than 2,500 grams	2000 2001 2002 2003 2004 *2005*	4.9 4.9 5.0 5.1 5.2 *5.2*
2A	The percent of very low birth weight births.	2000 2001 2002 2003 2004 *2005*	1.1 1.1 1.2 1.2 1.2 *1.2*
2B	The percent of very low birth weight singleton births.	2000 2001 2002 2003 2004 *2005*	0.9 0.9 0.9 0.9 0.9 *0.9*
3A	The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger	2000 2001 2002 2003 2004 *2005*	6.9 6.3 5.9 6.2 5.8 *5.8*
3B	The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among children aged 14 years and younger	2000 2001 2002 2003 2004 *2005*	2.9 3.1 2.9 3.6 3.1 *3.1*
3C	The death rate per 100,000 due to motor vehicle crashes among youth aged 15 through 24 years.	2000 2001 2002 2003 2004 *2005*	14.4 19.0 21.0 21.0 19.9 *19.9*

Health Status Indicators		*Year*	*Indicator*
4A	The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.	2000 2001 2002 2003 2004 *2005*	339.3 342.8 343.9 347.0 260.8 *260.8*
4B	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.	2000 2001 2002 2003 2004 *2005*	40.0 37.5 38.4 38.0 36.8 *36.8*
4C	The rate per 100,000 of nonfatal injuries due to vehicle crashes among youth aged 15 through 24 years.	2000 2001 2002 2003 2004 *2005*	146.0 155.2 165.0 166.5 161.9 *161.9*
5A	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia	2000 2001 2002 2003 2004 *2005*	21.8 21.9 22.3 22.2 22.3 *22.3*
5B	The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.	2000 2001 2002 2003 2004 *2005*	7.1 7.6 8.2 8.4 8.6 *8.6*